STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155385	A. BUILDING 00 B. WING	07/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT CARE CENTER	1555 COMMERCE STREET LOGANSPORT, IN46947

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: July 25, 26, 27, 28, 2011 Facility number: 000466 Provider number: 155385 AIM number: 100289810 Survey team: Tim Long, RN, TC Julie Wagoner, RN Census bed type: NF: 52 SNF/NF: 6 Total: 58 Census payor type: Medicaid: 58 Total: 58 Sample: 15 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 8/4/11 by Jennie Bartelt, RN.	F0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies.This plan of correction is prepared and submitted because of requirement under state and federal law.Please accept this plan of correction as our credible allegation of compliance.	
F0221 SS=D	The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Based on observation, record review and interview, the facility failed to attempt least restrictive approaches before applying physical restraints for 2 of 5 residents (Residents #7 and #21) reviewed for restraints in a sample of 15. Findings include: 1. Resident #7's clinical record was reviewed on 7/25/11 at 2:00 P.M.. The record indicated the resident had two separate current physician's orders, both dated 5/20/09, for a left elbow extender for self injurious behavior (SIB): "Apply left elbow extender prior to and during transport for SIB" and "Left elbow extender PRN (as needed) SIB". An observation was made on 7/25/11 at 1:55 P.M. of the resident in his wheelchair in his bedroom with a elbow extender on his left arm. At 2:16 P.M. the elbow extender was still on his left arm and CNA #1 confirmed the extender was on his left arm to keep him from biting his hand. The resident's health care plan dated 5/5/11 indicated the problem as "potential for injury to self and other related to history of acts of physical aggression such as biting self and others". Approaches were "1. Verbally redirect x 2. Calm quiet	F0221	1. Resident #7 had his elbow extender removed at 2:20pm as stated in the 2567 with no harm noted. The physician was contacted and the order was clarified to indicate use of the restraint after transportation is completed. Resident #21 was assessed and no harm was noted related to the facility not documenting least restrictive interventions prior to restraint application.2. All residents with restraint orders were assessed and their records reviewed to ensure appropriate orders, documentation and/or monitoring practices are in place.3. All staff were re-educated on the policy and procedure for the documentation of all interventions attempted prior to restraint application. Any resident identified with a PRN restraint order will be observed and the documentation will be reviewed at least 3 times weekly for compliance. These documented audits will be completed by the Social Service Director and/or designee.4. The Social Service Director will report the results of these audits to the QA committee monthly for 3 months and quarterly thereafter.	08/27/2011

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	location. 3. Provide personal care/explain prior to and during transport for SIB. 4. Apply left elbow extender prior to and during transport for SIB. 5. Apply left elbow extender PRN for SIB." The resident's July 2011 Mood and Side Effects Monitoring Form for behavior of bites self and with interventions of "1. Verbally redirect x 2; 2. Calm quiet location. 3. Provide personal care/explain prior to and during transport for SIB. 4. Apply left elbow extender prior to and during transport for SIB. 5. Apply left elbow extender 3.1 for SIB." The form listed no use of the PRN left elbow extender from 7/1/11 through 7/26/11. An interview with the Administrator on 7/28/11 at 10:10 A.M. indicated the resident came back from being transported on 7/25/11 by day programming at 12:50 P.M.. The Administrator indicated an unidentified CNA checked Resident #7 at 1:00 P.M. and did not remove the left elbow extender as the resident is usually upset when he first comes back. The Administrator indicated CNA #1 checked the resident at 2:00 P.M. and initially he was calm but when she tried to remove the left elbow extender he was still upset and tried to bite himself. The Administrator indicated at 2:20 P.M.			

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	CNA #1 removed the left elbow extender. An interview with the Administrator on 7/28/11 at 11:00 A.M. indicated the CNA's fill out a restraint record when a restraint is used and the nurses document on the treatment record when a restraint is put on. The administrator indicated the resident is usually still upset after returning from being transported and they usually leave on the left elbow extender for a while. The restraint record from July 2011 indicated the left elbow extender was put on at 9:00 A.M. and was on until discontinued by the CNA at 2:20 P.M.. The record indicated the CNA checked the resident at 1:00 P.M. and 2:00 P.M.. The record did not indicate the left elbow extender restraint was removed upon returning from the day programming outing at 12:50 P.M. The physician's order dated 5/20/09 indicated the left elbow extender was to be used prior to and during transportation. The physician's order for transportation did not indicate the left elbow extender was to be used after transportation was completed. None of the records provided concerning the use of the left elbow extenders on 7/25/11 from when the resident returned from being transported at 12:50 P.M. until			

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	the restraints were removed at 2:20 P.M. indicated any of the less restrictive approaches from the care plan were attempted before using the left elbow extender. 2. Resident #21's clinical record was reviewed on 7/27/11 at 2:00 P.M.. The record indicated the resident had physician's orders dated 6/4/09 for bilateral elbow extenders when awake PRN SIB. The resident's behavior/mood monitoring forms from April 2011 through July 2011 indicated the resident had 12 incidents of SIB requiring bilateral elbow extenders. 10 of the 12 incidents had no length of time indicating how long the restraints were used and did not indicate any interventions were attempted before the restraints were applied. The dates of the 10 incidents were: 5/3/11; 6/16/11; 6/17/11; 6/22/11; 6/23/11; 6/24/11; 7/5/11; 7/8/11; 7/18/11; 7/21/11. The resident's care plan initiated on 9/3/04 and most recently reviewed on 7/27/11 indicated the problem as "behavioral symptoms: resident demonstrates socially inappropriate behavior of licking her own hands which has resulted in skin breakdown in the past, related to diagnosis of Rett's Syndrome."			

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	Approaches were: verbally redirect and arm splints as ordered. An interview with the Social Service Director on 7/28/11 at 10:50 A.M. indicated staff had been reeducated to fill out the behavior/mood monitoring without putting they had tried the approach of verbally redirect before applying the bilateral elbow extenders. The method of filling out the behavior/mood monitoring sheets in May of 2011, under the section "how did you stop the behavior" was to enter the intervention of verbally redirect as well as bilateral elbow extenders. The Social Service Director indicated the verbal redirection attempts were always attempted first so staff were educated to not document on the form that verbal redirection was attempted before applying the elbow restraints. The Social Service Director indicated the form did not have a place to put interventions attempted before applying restraints on them. Review of the facility policy dated 8/05 for "Physical Restraint use and Application" included, but was not limited to: "Prior to initiation of a restraint, the licensed nurse will complete an assessment to indicate all other least restrictive measures that have been attempted and the outcome obtained."			

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	3.1-3(w) 3.1-26(o)			
F0363 SS=E	Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. Based on observation, record review, and interview, the facility failed to ensure the menu was followed with the appropriate serving sizes to provide nutritional adequacy for 24 of 56 residents who consume food in the facility. Findings include: During observation of the serving of the noon meal, conducted on 07/25/11 between 11:25 A.M. - 12:00 noon, the following was observed: Cook #2 served one walnut-sized ham ball with a serving spoon for the mechanical soft diets. The pureed diets ham balls were noted to be served with a #16 (2 ounce) scoop. The regular and pureed green beans were served with a #10 (3.5 ounce), and the mashed potatoes and the boiled potatoes were served with a #12 (3 ounce) scoop.	F0363	1. No residents were effected.2. No residents were effected.3. All dietary staff were re-educated on following the menus related to the appropriate serving sizes. The Dietary Manager and/or designee will check usage/accurracy of the meal serving process 3 times weekly for 4 weeks and 1 time weekly thereafter. The documented monitoring will vary with all three meals.4. The Dietary Manager will report the findings of these observations to the QA committee monthly times 3 months and quarterly thereafter.	08/27/2011

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Review of the menu for the meal indicated the residents on mechanical soft diets were to receive 3 ounces ham balls or a #10 scoop of ground ham balls, 1/2 cup of the scalloped potatoes, and 1/2 cup of the green beans. The residents on pureed diets were to receive two #8 (4 ounce) scoops of the ham ball which Cook #2 indicated had the bread and margarine pureed with it, #8 scoop (4 ounce) of scalloped potatoes, #10 (3.5 ounce) scoop of green beans.

Interview with the Food Service Supervisor, during the noon meal service on 07/25/11 indicated the wrong scoop sizes were being used. She then corrected Cook #6 and changed the scoops to the appropriate size; however, the cook then began to run out of the pureed ham balls. Interview with Cook #6 indicated she had weighed the ham balls, but she did not indicate the weight. A ham ball was weighed, utilizing the facility's scale and one ham ball was noted to weigh just over 1 ounce. The cook indicated she had only made 1 ham ball per resident. She indicated the ham ball recipe was new and she thought the 1 ounce size was what the recipe directed her to serve. The recipe did not indicate the serving size.

Interview with the Food Service

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	Supervisor, on 05/26/11 at 9:30 A.M. indicated the menus the facility was utilizing were new and the serving sizes were different from what the cooks were used to using. During observation of the puree process for the noon meal of 07/26/11, conducted on 07/26/11 at 9:30 A.M., Cook #5 indicated she had 17 residents who required pureed food. She indicated the facility policy was to make 4 extra servings of pureed food. The cook was noted to utilize a #6 (6 ounce) scoop and puree 21 six ounce servings of lasagna with an unmeasured amount of tomato juice. No recipe was used to measure the amount of tomato juice used for the pureed lasagna. The cook then started to fill the foil meal trays for residents who went to day programming. The cook initially started to use a #6 scoop but then was redirected to utilize two #8 (4 ounce) scoops of the pureed lasagna as per the menued portion. It was discovered after measuring all of the required pureed lasagna, there was not enough pureed lasagna prepared, however, two of the residents who received pureed food received 1/2 portions, one resident could not have the lasagna due to food allergies, so there was onlyone portion short. The Food Service Supervisor instructed Cook #7, who was coming in to relieve Cook			

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	#5, to puree one portion of ham. In addition, there were only two pre-made pans of lasagna cooked for the meal for all residents. The packaging had already been discarded and Cook #5 was unable to indicate the exact weight of each pan of lasagna. After removing the amount of lasagna required for the residents who were to receive pureed food, there was only approximately 1/3 of an approximately 9 by 11 inch pan of lasagna left. Cook #5 indicated she had 9 residents who received mechanical soft diets. It was unclear if there was enough lasagna left to serve the 9 residents who required mechanical soft food. The Food Service Supervisor indicated other food would be prepared in case they ran out of lasagna. The facility did run out of lasagna. There were no specific recipes utilized regarding the pureeing of the vegetables, ham balls, or lasagna. A policy form, dated 10/26/1994, titled Puree Foods, and indicated by the Food Service Supervisor as current, indicated the following: "...1. Look at the census sheet to find total number of residents on puree diets, 2. Take number of residents on puree diets + 4 extra = total servings needed to puree, 3. Place a serving for each puree, in the food processor, (following portion size on menu). Blend in food processor adding			

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	liquid (if necessary) to make puree food a pudding consistency. Note: only use liquids such as milk, broth, gravy, or juices. never use water. 4. After food is blended to a pudding consistency, pour puree mixture into clear plastic, two quart measure, 5. Measure in cups - round down to the nearest cup and divide by total serving pureed, this will give you an amount that each puree is to receive. Use the chart to determine the scoop to use, to portion up food. (This will assure that each resident on a puree diet receives the correct portion)...." Review of the Scoop size chart indicated the 1/2 cup scoop, #8 provided 4 - 5 ounces of food, the #12 scoop provided 1/3 cups or 2 1/2 - 3 ounces, the #10 scoop provided 1/3 cups plus 2 tablespoons of food or 3 - 4 ounces, the #16 scoop provided 1/4 cups or 2 - 1/4 ounce. Interview with Cook #6, during the serving of the noon meal on 07/25/11 at 11:30 A.M., indicated she thought it was okay to use the #12 and #10 scoop because they both provided 3 ounces of food. 3.1-20(i)(1) 3.1-20(i)(4)			

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F0371 SS=E	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure food was prepared, stored, and served in sanitary conditions. This potentially affected all 24 residents in the facility who consumed food of 56 total residents. Findings include: During the sanitation tour of the kitchen in the facility, conducted on 07/25/11 between 10:00 A.M. - 10:30 A.M., the following was observed: Two of five bowls stored on a compartmentalized cart, stacked on top of one another was noted to be put away dirty with dried food particles Ten of twelve plates, also stored on the compartmentalized cart, stacked on top of one another, were noted to be put away dirty and/or wet with visible liquid in between the plates and visible food particles on the plates. Five foil metal meal trays with pureed	F0371	1. No residents were effected.2. No residents were effected.3. The concerns identified in the 2567 were immediately corrected. All dietary staff were re-educated on the Dishwashing and Racking Procedure, Food Safety: Dry Storage/Cold Storage, Thawing Procedure of Meats, Cleaning Schedule and Food Handling. The Dietary Manager and/or designee will the complete the Kitchen Sanitation checklist at least 1 time weekly ongoing to ensure compliance.4. The Dietary Manager will report the findings of these observations to the QA committee monthly times 3 months then quarterly thereafter.	08/27/2011

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	green beans and mashed potatoes were stored uncovered in a refrigerator. There were various food items, including but not limited to yogurt cups, juice stored on the shelf above the uncovered meal trays. The shelf above the stove, on which hot pads were stored, was dusty. There was a bag of diced chicken breast, dated 07/19/11, in the walk in refrigerator. During interview at this time, the Food Service Supervisor indicated the chicken was to be cooked for the evening meal on 07/25/11. She stated she thought perhaps the wrong date had been written on the tray of chicken breast, but later indicated the chicken breast had been in the refrigerator too long. During the observation of pureeing lasagna, on 07/26/11 at 9:30 A.M., Cook #5, was noted to puree ten servings of Italian blend vegetables in the food processor. After emptying pureed vegetables into a pan, she then placed the food processor bowl back onto the motor unit and with her bare hands, which had handled the outside of the food processor, spoons, and pan handles, she reached in the adjusted the blade so it fit snugly onto the motor unit, as she prepared to puree more vegetables.			

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	3.1-21(i)(2) 3.1-21(i)(3)			
F0458 SS=E	Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. Based on observation, record review and interview, the facility failed to provide 80 square feet for each resident for 9 of 56 residents in the facility in 4 of 25 rooms (Rooms #1, 16, 18, 19). Findings include: During the entrance conference on 7/25/11 at 10:15 A.M., the Administrator indicated neither the measurements of the rooms nor the number of beds in the rooms had changed since the room measurements had been obtained prior to the last survey. During the initial tour on 7/25/11 at 10:30 A.M., accompanied by the Administrator, the following rooms were observed: Room #1: 3 beds for resident occupancy; ROOM #16: 3 beds for resident occupancy; ROOM 18: 4 beds for resident occupancy; ROOM #19: 4 beds for resident	F0458	A new request for waiver was submitted on 8/16/2011 to the Indiana State Department of Health for a Room-Size Waiver for Title 19 NF room #'s 1, 16, 18 & 19.	08/27/2011

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	occupancy; Review of the recorded square footage of the rooms which had been measured by Life Safety Code were as follows: ROOM #1: 3 beds/NF 238.8 square feet/79.6 square feet for each resident. ROOM #16: 3 beds/NF 237.9 square feet/79.3 square feet for each resident. ROOM #18: 4 beds/NF 319.6 square feet/79.9 square feet for each resident. ROOM #19: 4 beds/NF 319.6 square feet/79.9 square feet for each resident. 3.1-19(1)(2)			
F0465 SS=E	The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure food was prepared, stored, and served in sanitary conditions. This potentially affected all 24 residents in the facility who consumed food of 56 total residents. Finding includes: During the sanitation tour of the kitchen in the facility, conducted on 07/25/11 between 10:00 A.M. - 10:30 A.M., the following was noted:	F0465	1. The ceiling tiles identified in the 2567 were immediately replaced.2. All other ceiling tiles were observed to identify any that were bowed and/or rust stained and none were identified.3. The ceiling tiles were added to the current Kitchen Sanitation checklist and will be monitored at least 1 time weekly ongoing by the Dietary Manager and/or designee.4. The Dietary Manager will report the results of these audits to the QA committee monthly times 3 months and quarterly thereafter.	08/27/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155385	A. BUILDING 00 B. WING	07/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	Ceiling tiles beside an outside window and above the dishwasher were noted to be bowed and heavily rust stained. Interview with the Food Service Supervisor, on 07/25/11 at 10:15 A.M. indicated the roof had leaked onto the ceiling tiles and damaged them. She stated the roof had been repaired. 3.1-19(f)			